DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 04-006

2. STATE: Wisconsin

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: 07/01/04

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447.250

7. FEDERAL BUDGET IMPACT:
a. FFY 2004 $1,800K
b. FFY 2005 $7,200K

8. CURRENT PAGES: Attachment 4.19-A pages 3.1, 4, 20, 25.1, 28.1, ~~28~~, 32, 48, 50, 51, 52 .....

9. NEW PAGES: Same

10. SUBJECT OF AMENDMENT: Inpatient Hospital Rates

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT Robert Blanc
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL: Mark B. Moody

13. TYPED NAME: Mark B. Moody

14. TITLE: Administrator, Division of Health Care Financing

15. DATE SUBMITTED: September 29, 2004

16. RETURN TO:
Mark B. Moody
Administrator, Division of Health Care Financing
1 W. Wilson St.
P.O. Box 309
Madison, WI 53701-0309

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: SEP 30 2004

18. DATE APPROVED: May 10, 2005

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL - 1 2004

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Dennis G. Smith

22. TITLE: Director, CMSO

23. REMARKS:

RECEIVED
SEP 30 2004
DMCH - Milwaukee

FORM HCFA-179 (07-92)

3520 Hospitals Not Located In Wisconsin and Border Status Hospitals

Hospitals not located in Wisconsin which provide inpatient services to WMAP recipients may be reimbursed for their services. Certain of these hospitals have been granted "border status" by the WMAP. Others do not have border status under the WMAP (non-border status hospitals)

Non-Border Status Hospitals. Out-of-state hospitals which *do not have border status* are reimbursed under the DRG based payment method described in section 10000 herein. Payment is based on a standard DRG base rate which does not recognize any hospital-specific differences such as capital costs, differences in wage areas and disproportionate share adjustments. A non-border status hospital may request an adjustment for many of these factors through the administrative adjustments described in section 10400.

All non-emergency services at out-of-state hospitals which do not have border status require prior authorization from the WMAP. This differs from the prior authorization requirements for in-state and border status hospitals.

Minor Border Status Hospitals. Border status hospitals are divided into minor and major border status hospitals. Minor border status hospitals are those border status hospitals which do not meet the criteria described below for a major border status hospital. Minor border status hospitals are reimbursed according to section 10000 in the same manner as non-border status hospitals and may request the administrative adjustments to payment rates as described in that section. A minor border status hospital is required to provide an audited cost report to the Department (see §4022).

Major Border Status Hospitals. Major border status hospitals are reimbursed according to the DRG based payment method described under section 5000. This is the same DRG method as is used for in-state hospitals. It provides a rate that takes into account hospital-specific costs for such as capital costs.

Administrative Adjustments To Rates. Major border status hospitals may request administrative adjustments to their payment rates under section 11000.

Use of Cost Report In Rate Setting. As described in section 4000, a major border status hospital must submit a current audited cost reports to the Department for establishing certain components of their payment. The specific components include the disproportionate share adjustment (§5240), outlier payments (§4322), and capital cost payments (§5420).

Criteria For Major Border Status. Major border status hospitals are those border status hospitals which have had 75 or more WMAP recipient discharges or at least $ 350,000 or greater inpatient charges for services provided to WMAP recipients for the combined two rate years ending in the calendar years preceding the current annual rate update. Not included in these amounts are discharges and charges for: (1) Medicaid HMO covered stays, (2) stays which were paid in full or part by Medicare, (3) stays paid in full by a payor other than Medicare or Medicaid. Paid in full means the amount received by the hospital equals or exceeds the amount the WMAP would have paid for the stay. For each rate year, the Department will assess the discharges and charges of each border status hospital and notify the hospital of its standing as a major or minor border status hospital. For example, the following table shows the years used for a series of annual rate updates.

Annual Rate Update Effective Date	Rate Years Looked At for Discharges and Charges
July 1, 1996	July 1993 to June 1994 and July 1994 to June 1995
July 1, 1997	July 1994 to June 1995 and July 1995 to June 1996

Rehabilitation Hospitals With Border Status. A major border status hospital which the Department determines qualifies as a rehabilitation hospital, as defined in section 3000, will be reimbursed on a prospective rate per diem according to section 6300 otherwise the hospital will be paid under the DRG based payment method of section 5000. A minor border status rehabilitation hospital may request payment at a rate per diem according to section 10469.

Alternative Payments To Border Status Hospitals For Certain Services . For any out-of-state hospital, border status or not, all inpatient stays are reimbursed under the DRG based payment method except AIDS patient care, ventilator patient care, unusual cases and brain injury care will be reimbursed under the alternative payment methods described in section 7000 if the hospital requests and qualifies for the alternative reimbursement according to section 7000.

SECTION 4000
COST REPORTING

4010 General

Every in-state hospital participating in the Wisconsin Medical Assistance Program (WMAP) will prepare a Title XIX cost report. Major border status hospitals will submit their audited Medicare cost reports. Hospitals will be instructed regarding any supplemental worksheets and additional information that may be specifically required by the WMAP.

4020 Cost Report Due Date

4021 In-State Hospitals.
In-state hospital providers must submit the cost report and accompanying supplemental schedules to the Department's audit intermediary by the date required by Medicare for submission of the cost report. If a provider is granted an extension for Medicare, the WMAP will automatically extend its deadline.

4022 Major and Minor Border-Status Hospitals.
Both major and minor border-status hospitals must submit Medicare audited cost reports to the Department within sixty (60) days of the Medicare audit being completed. A hospital not participating in the Medicare program should submit the cost report it provided the Medicaid program in its state. An audit should be considered completed upon the hospital receiving the Medicare audit report. If the hospital is pursuing any appeal of the audited Medicare cost report, the hospital should submit the audited cost report to the Department along with a description of the items being appealed. Send a copy of the audited cost report to:

Hospital Unit
Bureau of Health Care Financing
P.O. Box 309
Madison, Wisconsin 53701-0309.

Audited Cost Report Used In Rate Setting. For major border-status hospitals, the Department uses a hospital's audited cost report on file with the Department to establish rates. If that cost report is for a fiscal year that is more than three years old, the hospital can request an administrative adjustment for use of a more current cost report in rate setting. Such an administrative adjustment is discussed under section 11900, item B (inpatient plan page 43).

4050 Gains and Losses of Depreciable Assets

Depreciable assets may be disposed of through donation, sale, scrapping, demolition, abandonment or involuntary conversion such as condemnation, fire, theft or other casualty. The gain or loss on such a disposition is not recognized for reimbursement under the Wisconsin Medicaid Program. This means that for dispositions occurring after June 30, 2004 the WMP will not recover a portion of any gains and will not provide supplemental payments for a portion of the losses.

Depreciable assets may be disposed of and replaced with depreciable assets through trade-in or exchange or, in the case of facilities and land improvement, demolition to clear land for use by or adjacent to replacement facilities. The gain or loss on such disposed assets is to be recognized in the capitalized cost of the replacement assets in accord with generally accepted accounting principals.

4060 Allowed Capital Cost Upon Change of Ownership

In establishing an appropriate allowance for depreciation and for interest on capital indebtedness with respect to an asset of a hospital which has undergone change of ownership, Medicare allowable cost principles now in effect or as may be amended govern the allowableness of costs except when provisions of this plan specifically describe a variance from Medicare principles.

5500 DIRECT MEDICAL EDUCATION PAYMENT UNDER DRG PAYMENT SYSTEM

5510 General

As of July 1, 1997, an amount is added to a hospital's specific base DRG rate for costs of its direct medical education program. This payment amount is prospectively established based on an individual hospital's past direct costs of its medical education program. Prior to July 1, 1997, direct medical education program costs were paid under a prospectively determined monthly payment amount without regard to the number of WMP recipient discharges during the month.

5530 Calculation for Hospitals Located In Wisconsin

Base Cost Report. For hospitals located in Wisconsin, the direct medical education payment is determined from a hospital's most recent audited cost report on file with the Department as of the April 30th prior to the annual rate update. However, the Department may, at its option, use an audited cost report it receives later if the end date of the period of the cost report on file with the Department as of the April 30th date precedes the beginning date of the rate year by more than three years, three months.

If the cost report on file is more than three years old, the hospital may request an administrative adjustment to the direct medical education payment amount pursuant to §11900, item B.

Significant changes in a hospital's direct medical education program costs after the base cost reporting period may be considered pursuant to the available administrative adjustment under section 11900, item D.

For combining hospitals, section 6480 below describes the cost report to be used for calculating the capital payment.

No Audited Cost Report Available. For hospitals located in Wisconsin for which there is no audited cost report available, an estimated direct medical education payment is calculated based on the best available hospital data, as determined by the Department, such as an unaudited cost report or financial statements. The direct medical education payment will be adjusted retrospectively when an audited cost report becomes available to the Department.

Calculation. The direct medical education payment for a hospital located in Wisconsin is determined from cost information from each individual hospital's base cost report. An example calculation is in section 24000 of the appendix.

1. The direct medical education cost attributable to WMP inpatient services is determined by multiplying the allowed inpatient cost attributable to WMP recipient inpatients by the ratio of total allowed inpatient direct medical education costs to total allowed inpatient costs.
2. The resulting amount is inflated through the rate year by the DRI/McGraw Hill, Inc. CMS Hospital Market Basket inflation rate and increased by any disproportionate share adjustment percentage applicable to the individual hospital.
3. The resulting gross amount is divided by the number of WMP recipient discharges for the period of the audited cost report.
4. The resulting amount per discharge is divided by the average DRG case mix index per discharge. For rate year July 1, 2004 through June 30, 2005, the result is also multiplied by budget factor of 1.00.
5. The result is the hospital's specific base payment for its direct medical education program at a 1.00 DRG weight. This amount is added to the hospital's specific DRG base rate described in section 5210.

Payment for a specific patient's stay is determined by multiplying the base payment amount by the DRG weighting factor for a specific patient's stay.

TN # 04-006
Supersedes
TN # 97-013

Approval date MAY 10 2005 Effective date 07/01/04

5900 Reimbursement for Critical Access Hospitals

Definition: A critical access hospital (CAH) is a hospital that meets the requirements under 42 CFR Part 485, Subpart F and is designated as a critical access hospital byCMS, and is designated as a critical access hospital by the Department.

Critical access hospitals are reimbursed the lower of the hospital's allowable cost or charges for the services provided to Medicaid recipients.

If payments exceed costs, the Department will recover excess payments from the hospital.

If costs exceed interim payments, the Department will reimburse the hospital the amount by which a hospital's costs exceed payments.

The Department will calculate an interim discharge rate based on a hospital's most currently audited cost report. If no cost report is available, the best available data will be used to set an interim rate.

Total inpatient payments may not exceed charges as described in section 9000.

6470 SERVICES COVERED BY PER DIEM RATE PAYMENTS UNDER SECTION 6000

All covered services provided during an inpatient stay, except professional services described in §6480, shall be considered hospital inpatient services for which per diem payment is provided under this section 6000. (Reference: Wis. Admin. Code, HFS 107.08(3) and (4))

6480 PROFESSIONAL SERVICES EXCLUDED FROM PER DIEM RATE PAYMENTS UNDER SECTION 6000

Certain professional and other services are not covered by the per diem payment rates under this section 6000. To be reimbursed by the Wisconsin Medicaid program, professional services must be billed by a separately certified provider and billed on a claim form other than the UB-92 hospital claim form. The following services are excluded from the per diem payment rates and may be billed separately when the professionals are functioning in a capacity listed below.

Physicians	Optometrists	Pharmacy, for take home drugs on the date of discharge
Psychiatrists	Hearing aid dealers	
Psychologists	Audiologists	Durable medical equipment and supplies for non-hospital use
Physician assistants	Podiatrists	
Nurse midwives	Independent nurse practitioners	Specialized medical vehicle transportation
Chiropractors	Anesthesia assistants	
Dentists	Certified registered nurse anesthetists	Air, water and land ambulance

(Next page is page 29)

7900 PAYMENT RATES FOR SERVICES EXEMPTED FROM DRG PAYMENT SYSTEM

These payment rates are established by applying the general payment rate increase provided by the state's biennial budget to the rate in effect for the prior rate year.

For Section	Services	Rate Per Diem Effective July 1, 1996	Effective July 1, 1997	Effective July 1, 1998
7100	AIDS Acute Care	$ 570	$ 582	$ 597
7100	AIDS Extended Care	$ 314	$ 321	$ 329
7200	Long-Term Ventilator Services	$ 444	$ 453	$ 465
7500	Brain Injury Care			
	Neurobehavioral Program Care	$ 780	$ 796	$ 816
	Coma-Recovery Program Care	$ 937	$ 957	$ 981

7990 SERVICES COVERED BY PAYMENT RATES IN SECTION 7900 ABOVE

All covered services provided during an inpatient stay, except professional services described in §7992, are considered hospital inpatient services for which payment is provided under the payment rates listed in section 7910 above. (Reference: Wis. Admin. Code, HFS 107.08(3) and (4))

7992 PROFESSIONAL SERVICES EXCLUDED FROM PAYMENT RATES IN SECTION 7910 ABOVE

Certain professional and other services are not covered by the payment rates listed in section 7910 above. To be reimbursed by the Wisconsin Medicaid program, professional services must be billed by a separately certified provider and billed on a claim form other than the UB-92 hospital claim form. The following services are excluded from the above payment rates and may be billed seperately when the professionals are functioning in a capacity listed below.

Physicians	Optometrists	Pharmacy, for take home drugs on the date of discharge
Psychiatrists	Hearing aid dealers	
Psychologists	Audiologists	Durable medical equipment and supplies for non-hospital use
Physician assistants	Podiatrists	
Nurse midwives	Independent nurse practitioners	Specialized medical vehicle transportation
Chiropractors	Anesthesia assistants	
Dentists	Certified registered nurse anesthetists	Air, water and land ambulance

APPENDIX SECTION 24000
EXAMPLE CALCULATION

HOSPITAL-SPECIFIC BASE DIRECT MEDICAL EDUCATION PAYMENT
For Wisconsin Hospitals

ROUTINE & SPECIAL CARE COST, MEDICAL EDUCATION COSTS. . . . . (Cost Report Source: Worksheet D part 1 line 101, column 3, medical education costs)		$70,475
ANCILLARY MEDICAL EDUCATION COSTS. . . . . (Cost Report Source: Worksheet D part II line 101, column 3, medical education costs)	+	$125,051
TOTAL MEDICAL EDUCATION COSTS	=	$ 195,526
TOTAL COSTS. . . . . Divide by (Cost Report Source: Worksheet C line 101 minus lines 34 to 36 and 63 to 94)		$23,908,575
RATIO MEDICAL EDUCATION COSTS TO TOTAL COSTS.	=	.0082
TOTAL T-19 INPATIENT COSTS . . . . . (Cost Report Source: Supplemental worksheet E-3 part III line 1)	X	$1,663,287
T-19 DIRECT MEDICAL EDUCATION COSTS	=	$13,639
DRI INFLATION FACTOR.	X	1.192
INFLATED DIRECT MEDICAL EDUCATION COSTS	=	16,258
DISPROPORTIONATE SHARE FACTOR (Note A).	X	1.043
ADJUSTED FOR DISPROPORTIONATE SHARE.	=	$16,957
WMP RECIPIENT DISCHARGES from audited cost report . . . . . Divide by		196
DIRECT MEDICAL EDUCATION PROGRAM COST PER DISCHARGE	=	$ 87
AVERAGE DRG CASE MIX WEIGHT (INDEX) PER DISCHARGE. . . . . Divide by		1.2370
HOSPITAL-SPECIFIC BASE DIRECT MEDICAL EDUCATION PAYMENT . . . . . = See Note B below		**$ 70**

Note A -- If no disproportionate share adjustment applies to hospital, then a 1.00 multiplier is used

Note B –The direct medical education payment illustrated above is multiplied by a budget reduction factor of 1.00. For the example above, $70 is multiplied by . 1.00 providing a $70 direct medical education payment.

APPENDIX SECTION 27000
AREA WAGE INDICES
Effective July 1, 2004

The following wage area indices are based on hospital hours and salaries for hospital fiscal years that began in federal fiscal year October 1999 through September 2000.

WAGE AREAS FOR WISCONSIN HOSPITALS	For Original Remaining Hospitals in Area	For Hospitals Reclassified to Area
Appleton/Neenah/Oshkosh	.9403 See Note A	None
Eau Claire	.9403 See Note A	None
Green Bay	.9788	.9788
Janesville/Beloit	.9403 See Note A	None
Kenosha	All hospitals reclassified to Chicago for 1.0041 index	
La Crosse	.9582	None
Madison	1.0535	1.0535
Milwaukee County	1.0504	None
Ozaukee-Washington-Waukesha Counties	1.0193	.9403 See Note A
Racine	All hospitals reclassified to Ozaukee-Washington-Waukesha Counties for .9403 index (See Note A)	
Sheboygan	.9403 See Note A	None
Superior, WI / Duluth, MN	1.0901	None
Wausau	1.0121	1.0121
Rural Wisconsin	.9403 See Note A	None

Note A – Section 5224, page 9, requires that " the index applied to any hospital located in Wisconsin shall not be lesser than the rural Wisconsin index." The rural Wisconsin index is .9403.

WAGE AREAS FOR BORDER STATUS HOSPITALS	For Original Remaining Hospitals in Area	For Hospitals Reclassified to Area
Twin Cities, Minnesota (St. Paul, Minneapolis, Coon Rapids, Edina, Lake City, Robinsdale, Stillwater, Chisago City, Hasting)	1.1433	None
Duluth, Minnesota	1.0901	None
Rochester, Minnesota	1.2140	None
Rockford, Illinois	.9991	None
Dubuque, Iowa	.9193	None
Chicago - Woodstock, Harvard, Illinois	1.0825	1.0041
Iowa City, Iowa	.9868	None
Rural Illinois	.8793	None
Rural Minnesota	1.0393	None
Rural Michigan	.9250	None

APPENDIX SECTION 27100
DISPROPORTIONATE SHARE ADJUSTMENT AMOUNTS

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FOR SECTION 5243, MEDICAID UTILIZATION METHOD

Effective July 1, 2004, a hospital's disproportionate share adjustment factor under section 5243 is calculated according to the following formula where:

17.10% = Medicaid inpatient utilization rate at one standard deviation above the statewide mean Medicaid utilization rate.

M = The hospital's Medicaid inpatient utilization rate for hospitals with a utilization rate greater than 17.10%.

.26 = Linear slope factor allowing proportional increase in disproportionate share adjustment as utilization rate (M) increases.

Formula:

[(M -17.10%) X .26] + 3% = Hospital's Specific Disproportionate Share Adjustment Percentage for section 5243

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FOR SECTION 8100, THE ESSENTIAL ACCESS CITY HOSPITAL (EACH) DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT

Annual Statewide Funding

The annual statewide funding for the essential access city hospital (EACH) disproportionate share hospital adjustment is $4,748,000.

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FOR SECTION 8200, THE GENERAL ASSISTANCE DISPROPORTION SHARE HOSPITAL ALLOWANCE

Maximum Available Funding

For the rate year July 1, 2004 through June 30, 2005, and each rate year thereafter, the maximum available funding for the general assistance disproportionate share hospital allowance (GA-DSH) under section 8200 is $32,921,171.

APPENDIX 27200
INFLATION RATE MULTIPLIERS
FOR ADMINISTRATIVE ADJUSTMENTS
FOR RATES EFFECTIVE JULY 1, 2004 THROUGH JUNE 30, 2005

Inflation rates to be applied in calculating the following administrative adjustments of §11900:
Item B -- Capital and direct medical education payment based on cost report more than three years old
Item C -- Capital payment adjustment for major capitalized expenditures
Item D -- Adjustment for changes in medical education

Month Fiscal Year Ended	Inflation Multiplier
1998	
Jan-1998	1.2899
Feb-1998	1.2899
Mar-1998	1.2899
Apr-1998	1.2749
May-1998	1.2749
Jun-1998	1.2749
Jul-1998	1.2627
Aug-1998	1.2627
Sep-1998	1.2627
Oct-1998	1.2579
Nov-1998	1.2579
Dec-1998	1.2579
1999	
Jan-1999	1.2519
Feb-1999	1.2519
Mar-1999	1.2519
Apr-1999	1.2448
May-1999	1.2448
Jun-1999	1.2448
Jul-1999	1.2355
Aug-1999	1.2355
Sep-1999	1.2355
Oct-1999	1.2228
Nov-1999	1.2228
Dec-1999	1.2228
2000	
Jan-2000	1.2149
Feb-2000	1.2149
Mar-2000	1.2149
Apr-2000	1.2038
May-2000	1.2038
Jun-2000	1.2038
Jul-2000	1.1908
Aug-2000	1.1908
Sep-2000	1.1908
Oct-2000	1.1791
Nov-2000	1.1791
Dec-2000	1.1791

Month Fiscal Year Ended	Inflation Multiplier
2001	
Jan-2001	1.1634
Feb-2001	1.1634
Mar-2001	1.1634
Apr-2001	1.1512
May-2001	1.1512
Jun-2001	1.1512
Jul-2001	1.1403
Aug-2001	1.1403
Sep-2001	1.1403
Oct-2001	1.1314
Nov-2001	1.1314
Dec-2001	1.1314
2002	
Jan-2002	1.1199
Feb-2002	1.1199
Mar-2002	1.1199
Apr-2002	1.1114
May-2002	1.1114
Jun-2002	1.1114
Jul-2002	1.1003
Aug-2002	1.1003
Sep-2002	1.1003
Oct-2002	1.0902
Nov-2002	1.0902
Dec-2002	1.0902
2003	
Jan-2003	1.0760
Feb-2003	1.0760
Mar-2003	1.0760
Apr-2003	1.0707
May-2003	1.0707
Jun-2003	1.0707
Jul-2003	1.0595
Aug-2003	1.0595
Sep-2003	1.0595
Oct-2003	1.0502
Nov-2003	1.0502
Dec-2003	1.0502

Month Fiscal Year Ended	Inflation Multiplier
2004	
Jan-2004	1.0403
Feb-2004	1.0403
Mar-2004	1.0403
Apr-2004	1.0346
May-2004	1.0346
Jun-2004	1.0346
Jul-2004	1.0233
Aug-2004	1.0233
Sep-2004	1.0233
Oct-2004	1.0154
Nov-2004	1.0154
Dec-2004	1.0154
2005	
Jan-2005	1.0077
Feb-2005	1.0077
Mar-2005	1.0077
Apr-2005	1.0000
May-2005	1.0000
Jun-2005	1.0000
Jul-2005	.9902
Aug-2005	.9902
Sep-2005	.9902
Oct-2005	.9836
Nov-2005	.9836
Dec-2005	.9836
2006	
Jan-2006	.9756
Feb-2006	.9756
Mar-2006	.9756

Example Use of Table
Costs from a fiscal year ended September 2001 are inflated to the rate year ending June 2005 by applying the above 1.1403 multiplier to the costs.

For a fiscal year ended December 2004, apply the 1.0154 multiplier to costs

(7/1/04, TN # 04-006)